MARYLAND HEALTH CARE COMMISSION

COMAR 10.25.06

Maryland Medical Care Data Base and Data Collection

Data Submission Manual

Formatted for 2008 Medical Care Data Base due June 30, 2009

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
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Section I - INTRODUCTION

New & Modified !

1. **NEW!** The term **"ENCOUNTER"** has been replaced by **"PROFESSIONAL SERVICES"** in the file documentation, file layouts, and data dictionary. "Professional Services" is a more accurate description of the contents of this file and will better distinguish this file from the "Institutional Services" file that will be required as part of the 2009 MCDB submission.

2. **NEW!** The former "Coverage Type" variable has been reconfigured into two variables: **"Plan Liability"** (risk or Administrative Services Only, **pg. 17**) and a *revised* **"Coverage Type"** variable (**pg. 16**, **pg. 51**) with new coding options to better match the types of coverage currently available in Maryland—including the Health Insurance Partnership plan. Please note that the codes for some currently existing coverage types have changed.

3. **NEW!** The Professional Services File Layout has been expanded to include the **Plan Liability** variable. (File layout extended, pg. 29, pg. 31 and pg. 40)

4. **NEW!** The Professional Services File Layout (pg. 29, pg. 31 and pg. 40) and the Pharmacy Data File Layout (pg. 32 and pg. 42) have been expanded to include a new field for the **National Provider Identifier (NPI) Number** of the Servicing/Prescribing Practitioner.

5. **NEW!** The Patient Liability field on the Professional Services File Layout (pg. 29, pg. 31 and pg. 40) and Pharmacy Data Report (pg. 32 and pg. 42) has been replaced with three new financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. (File layout extended)

6. **NEW!** Submissions that do not meet the specific thresholds listed in **Appendix G** (pg. 53 will be returned (unless a waiver was obtained).

7. **Modified!** The Maryland Health Professional **Board Code** has been **eliminated** from the Provider Directory File Layout (pg. 33 and pg. 45).

8. **Modified!** The Professional Services File Layout – **Variable Format** (pg. 30, pg. 31, and pg. 37) has been modified and rearranged. If using the Variable Format, the number of line items completed in the variable portion (data elements 18-38) must match the value entered for this data element, maximum value for this data and number of line items is 26.

Important Reminders !

9. The Delivery System Type category was expanded to include **Exclusive Provider Organizations (EPOs)** (pg. 18, pg. 36).

10. The Pharmacy Data File Layout was expanded to include a field for the **Prescription Claim Number** (pg. 32, pg. 42).

11. The Provider Directory File Layout was expanded to include: the **National Provider Identifier (NPI) number** and the **Maryland Health Professional License number** (pg. 33, pg. 45).

12. The Professional Services File – Data Submission Documentation – **Section 1. Professional Services Control Total Verification table** (pg. 8) columns were renamed. The Total Billed Amount column was removed; and a new column added – **Total Amount Paid (Insurer + Patient)**; "Insurer" inserted to read **Total Insurer Reimbursement Amount**.

13. The Professional Services File – Data Submission Documentation – **Section 2. Service From Date Frequency table** (pg. 8) eliminated the # Claims column, and added a service volume distribution column.

14. The Professional Services File – Data Submission Documentation – **Section 3. Procedure Code Aggregation table** (pg. 9) was dropped. However, questions regarding homegrown procedure codes and capitated services remain.

15. The type of **Service Unit Indicator** field was expanded to include **Laboratory Tests – Code "7"** (see pg. 10 and pg. 38).

16. **Patient Date of Enrollment** in plan – Date is **20080101** if patient is enrolled at start of 2008. Enter other date if patient **not enrolled** at start of year but enrolled during 2008 (pg. 39 – data dictionary).

17. **Patient Date of Disenrollment** in plan **– Leave blank** if patient is **still enrolled** on **20081231**. If patient **disenrolled** before end of year, enter date disenrolled (p. 39 – data dictionary).

18. **16-month Reporting Period –** claims adjudicated from January 1, 2008 through April 30, 2009 for services received on or after January 1, 2008.

19. **Consumer Directed Health Plan (CDHP), Field #4 on the Professional Services Layout.** Please identify Consumer Directed Health Plan alone or with Health Savings Account (HSA) or Health Resources Account (HRA).

    - Pg. 28 (fixed), pg. 30 (variable) – Coding: 0 = No; 1 = CDHP alone or w/HSA or HRA

    - Please provide number of services for Consumer Directed Health Plans on pg. 18

20. **Patient Covered by Other Insurance, Field #6 on the Professional Services Layout** (pg. 28). If you believe you are the **primary payer** then please code "0" (zero) in this field (pg. 36).

21. **Service Location Zip Code** (pg. 29, pg. 30 and pg. 38) – **Please make an effort to fill this field**!

PLEASE NOTE !!

- The deadline for filing requests for waiver exemptions or format exceptions is **May 15, 2009**. The data base contractor is not authorized to grant exceptions.

- A list of the Commission's internal data edit thresholds is provided in **Appendix G**.

- A timeline for the MCDB Data Expansion to include the **Institutional Claims File** and **Medical Eligibility File** and **Pharmacy Eligibility File** is provided in Appendix H.

DATA SUBMISSION MANUAL

Purpose: The Medical Care Data Base (MCDB) Data Submission Manual is designed to provide payers with guidelines of technical specifications, layouts, and definitions necessary for filing the reports specified under COMAR 10.25.06.01D. This manual is available in electronic form on the Commission's website at mhcc.maryland.gov.

Payer ID #: Please see Appendix F for a list of 2008 MCDB payers and assigned ID numbers. The assigned ID number is required on all submission media and documentation.

Questions regarding the information in this manual should be directed to:

Larry Monroe
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
Phone: (410) 764-3460 Fax: (410) 358-1236
lmonroe@mhcc.state.md.us (e-mail)

Please direct data processing inquiries to:

Mr. Jeff McCartney
Social & Scientific Systems, Inc.
8757 Georgia Avenue, 12th Floor
Silver Spring, MD 20910
Phone: (301) 628-3256 Fax: (301) 628-3201
JMcCartney@s-3.com (e-mail)

Data Completeness Summary Report

Payers who contributed to the 2007 Medical Care Data Base (submissions received June 2008) **were mailed a Data Completeness Summary Report in March 2009 that shows total number of recipients, services, and payments by delivery system, plan type, and coverage type for calendar years 2006 and 2007 data.**

Please use this report to evaluate changes between your 2007 data (submitted in June 2008) and this submission of data due June 2009. If there are decreases or increases in the total number of recipients, services, or payments above 10 percent you must provide detailed documentation with your current submission.

If you did not receive the 2007 Data Completeness Summary Report, please contact lmonroe@mhcc.state.md.us.

Data Set Glossary

Reporting Period: Claims adjudicated from January 1, 2008 through April 30, 2009 for **services received on or after January 1, 2008.**

Professional Services Report: Fee-for-service encounters and specialty care capitated encounters provided by health care practitioners and office facilities (i.e., CMS 1500 claims). ***This does not include hospital facility services documented on UB 92 claims forms.***

The following medical services must be included:

- Physician services
- Non-physician health care professionals
- Freestanding Office Facilities (radiology centers, ambulatory surgical centers, birthing centers, etc.)
- Durable Medical Equipment (DME)
- Prescription Drug (in a separate file)
- Dental – if services are provided under a medical benefit package
- Vision - if services are provided under a medical benefit package

Pharmacy Report: These data detail prescription drugs only.

Provider Directory Report: These data detail all health care practitioners and suppliers who provided services to enrollees during the reporting period. **Each professional service submission should be accompanied by a Provider Directory Report. In instances where the data come from different sources, a separate Provider Directory Report must be provided (with a crosswalk of every practitioner ID listed in the Professional Services Report) for each health care practitioner or supplier who provided services.**

Reporting Deadline: June 30, 2009

Number (#) of Services: Any health or medical care procedure or service rendered by a health care practitioner documented by CPT, HCPCS or locally defined code (i.e., homegrown medical procedure code).

- **VARIABLE FORMAT** – 1 service is equal to 1 line item, multiple line items can appear on a single record/claim.
- **FIXED FORMAT** – 1 service corresponds to 1 record/service. If a service includes more than 1 unit, it is still counted as 1 service.

Number (#) of Claims:

- **VARIABLE FORMAT** – Number of claims is equal to the number of CMS 1500 encounters (bills) submitted.
- **FIXED FORMAT** – Claims are equal to the number of CMS 1500 encounters (bills) originally received. Please note that when using the fixed format this number will not conform with the number of records submitted because multiple services may be reported on a single claim.

Payer Submission and Documentation Checklist

Please use this checklist as a guideline for your data submission.

	Item	Page #
☐	Professional Services Report layout – **Modified!**	28
☐	Pharmacy Report layout – **Modified!**	32
☐	Provider Directory Report layout – **Modified!**	33
☐	Media Format Information	34
☐	Payer ID# on all media & documentation	52

Did you include the necessary documentation in order to read your data?

☐	Copies of File Layouts	
☐	File Documentation – Section II	6
☐	Data Element Documentation – Section IV	15
☐	Coverage Type Mapping – **Modified!**	16
☐	Delivery System Mapping	18
☐	Consumer Directed Health Plan Mapping	18
☐	Practitioner Specialty Mapping	22
☐	Type of Bill Mapping	26

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

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Section II

FILE DOCUMENTATION

- **Professional Services File**
- **Pharmacy File**
- **Provider Directory**

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Medical Care Data Base Documentation Form

Payer Name (s):_____

Payer ID #: _____ **(See Appendix F for complete list of 2008 MCDB payers & Payer ID #s).**

Professional Services Data Contact: _____

Provider Directory Data Contact: _____

Pharmacy Data Contact: _____

Name/Title: _____

Address: _____

Telephone Number: _____

Facsimile Number: _____

E-mail Address: _____

PROFESSIONAL SERVICES
Media Type:
☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP NEW!

Number of Media: _____ Number of Claims: _____
Blocking Factor: _____ Number of Services: _____
Logical Record Length: _____
Fixed Format ☐ Variable Format ☐
Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

PROVIDER
Media Type:
☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP NEW!

Number of Media: _____ Number of Records: _____
Blocking Factor: _____ Logical Record Length: _____
Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

PHARMACY
Media Type:
☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP NEW!

Number of Media: _____ Number of Prescriptions:_____
Blocking Factor: _____ Logical Record Length:_____
Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

Please forward media and accompanying documentation to:

Mr. Jeff McCartney
Social & Scientific Systems, Inc.
8757 Georgia Avenue, 12th Floor
Silver Spring, MD 20910

PROFESSIONAL SERVICES FILE

DATA SUBMISSION DOCUMENTATION

1. Professional Services Control Total Verification

Please complete the following table by indicating the number of covered lives and number of services by delivery system type for the time period January 1, 2008 through April 30, 2009. **Use the average number of covered lives** (the average number of insured individuals and their dependents) **per year as the basis for your determination of enrollment.** In addition, specify the total payment information for all delivery system types. **Please compare this report to the 2007 Data Completeness Summary Report.**

			Payment Information			
Delivery System Type	**Covered Lives**	**# Services**	**Total Allowed Amount**	**Total Patient Liability***	**Total Insurer Reimbursement Amount**	**Total Amount Paid (Insurer+Patient)**
HMO, (non-Medicaid), HMO/POS include policies with "opt out" provision in this category						
PPO-POS (Point of Service Indemnity Plan)						
PPO or Other Managed Care						
Indemnity Care						
HMO-POS Rider						
EPO						
Other (specify)						
Total			**$**	**$**	**$**	**$**

* *"Total patient liability is equal to the sum of patient deductible, patient coinsurance/co-payment, and other patient obligations."*

2. Service From Date Frequency

Please complete the table below using the month and year segments for **Service From Date** (data element number 27 on the professional services **fixed** file layout). This table will provide an assessment of your data submission.

Service From Date Month/Year	# Services
Jan 2008	
Feb 2008	
Mar 2008	
Apr 2008	
May 2008	
Jun 2008	

Service From Date Month/Year	# Services
Jul 2008	
Aug 2008	
Sept 2008	
Oct 2008	
Nov 2008	
Dec 2008	

Service From Date Month/Year	# Services
Jan 2009	
Feb 2009	
Mar 2009	
Apr 2009	

A. Is this service volume distribution consistent with your experience?

☐ Yes ☐ **If no, please explain** _____

3. Homegrown Procedure Codes / Capitation Questions

A. Does this data submission include homegrown procedure codes*?

☐ No ☐ **If yes,** please provide in a separate electronic file a list of codes and definitions applicable to this submission.

* Note: Submissions that do not meet the 5% threshold for this variable will be returned unless the payer has obtained a waiver. (See Appendix G)

B. What types of services are capitated by your organization?

☐ Primary Care ☐ Laboratory ☐ Radiology ☐ Optometry ☐ Other _____

Are all of these services included in this submission? ☐ Yes ☐ No *(please explain)*

If a health maintenance organization (HMO) is <u>not</u> one of your product lines, and you are providing capitated services, please explain. *(attach additional sheets if needed)*

_____

4. Anesthesia Services

Restrict to: CPT 00100-01999
99100-99140

Value	Service Unit Indicator	# Services	# Units
2	Anesthesia Time Units *		
8	Minutes of Anesthesia *		
1	Transportation (ambulance air or ground) miles		
3	Services		
4	Oxygen Units		
5	Units of Blood		
6	Allergy Tests		
7	Laboratory Tests		

* Note: For Anesthesia Services, we would expect the Service Unit Indicator to have a value of "2" or "8".

A. Are base units included in the units field for these services?

☐ Yes ☐ No

B. Are anesthesia units associated with physical status modifiers counted when anesthesia payments are calculated?

(Physical status modifiers are used by some payers to compensate anesthesiology providers when the patient is very young, old, or frail. The modifiers are reported in the CPT modifier field.)

☐ Yes ☐ No

If yes, please supply the additional anesthesia units in the table below.

Physical Status Modifiers	**Anesthesia Units**
P1 – A normal healthy patient.	0
P2 – A patient with mild systemic disease.	
P3 – A patient with severe systemic disease.	
P4 – A patient with severe systemic disease that is a constant threat to life.	
P5 – A moribund patient who is not expected to survive without the operation.	
P6 – A declared brain-dead patient whose organs are being removed for donor purposes.	

PHARMACY FILE

DATA SUBMISSION DOCUMENTATION

1. Date Filled Frequency (Pharmacy)

Please complete the table below using the month and year segments for **Date Filled** (data element number 12 on the file layout). This table will provide an assessment of your data submission.

Month/Year	# Prescriptions	Month/Year	# Prescriptions
Jan 2008		Sep 2008	
Feb 2008		Oct 2008	
Mar 2008		Nov 2008	
Apr 2008		Dec 2008	
May 2008		Jan 2009	
Jun 2008		Feb 2009	
Jul 2008		Mar 2009	
Aug 2008		Apr 2009	

2. National Drug Code (NDC)

Please complete the table below with totals from your pharmacy claims data. Provide a total for NDC and all non-coded drugs. All remaining drug code totals should be summed under "*Not National Drug Codes*."

Code Range	Total Reimbursement Amount (data element #14)	# Prescriptions
NDC		
Not Coded		
NOT National Drug Codes		
TOTAL		

Comments:_____

_____

3. Mail Order Pharmacy Information

Mail Order Pharmacy NCPDP#	Name of Pharmacy

Note: Attach additional sheets if needed or provide a separate electronic file.

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Section III

SPECIAL INSTRUCTIONS for **FINANCIAL DATA ELEMENTS**

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Billing and Reimbursement Information

PROFESSIONAL SERVICES FILE

Each of the following financial fields must be recorded by line item. The value represented by each field **must be rounded to whole dollars** (i.e., no decimals) on the professional services file.

(Note: **Patient Liability** has been replaced with three new financial data elements: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**.)

Financial information includes:

- Billed Charge
- Allowed Amount
- Reimbursement Amount
- Patient Deductible **NEW!**
- Coinsurance/Co-payment **NEW!**
- Other Patient Obligations **NEW!**

The financial **format** must be consistent for all financial fields. **"+" signs are not acceptable.**

All Fee-for-Service (bill type = '1') debit and credit bills must be reconciled to final bills.

For Capitated Services (bill type = '8') billed charge, allowed amount, and reimbursement amount should be equal to –999.

All financials should be either numeric format (ASCII or EBCDIC) or signed overpunch.

Examples of **text format** which **must** be consistent for all financial fields include:

- 1997
- 1998
- 1999
- - 1997
- - 1998
- - 1999

Examples of **signed overpunch format** which **must** be consistent for all financial fields include:

POSITIVE

- 199{ = 1990
- 199A = 1991
- 199B = 1992
- 199C = 1993
- 199D = 1994
- 199E = 1995
- 199F = 1996
- 199G = 1997
- 199H = 1998
- 199I = 1999

NEGATIVE

- 199{ = **-**1990
- 199J = **-**1991
- 199K = **-**1992
- 199L = **-**1993
- 199M = **-**1994
- 199N = **-**1995
- 199O = **-**1996
- 199P = **-**1997
- 199Q = **-**1998
- 199R = **-**1999

PROFESSIONAL SERVICES FINANCIAL INFORMATION GLOSSARY

Line Item: A single line entry on a bill/claim for each health care service rendered. The line item contains information on each procedure performed including modifier (if appropriate), service dates, units (if applicable), and practitioner charges. The line item also includes **billed charge, allowed amount, patient deductible, patient coinsurance/co-payment, other patient obligations,** and **reimbursement amount** for that line item service**.**

Billed Charge: Dollar amount as billed by the practitioner for health care services rendered. Each line item of a claim/bill must include the practitioner's billed charges rounded to whole dollars.
(i.e., no decimals).

Allowed Amount: The retail amount for the specified procedure code. Each line item must include the payer's retail amount rounded to whole dollars **(i.e., no decimals).**

Patient Deductible: The fixed amount that the patient must pay for covered medical services before benefits are payable.
Patient Coinsurance/Co-payment: The specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.
Other Patient Obligations: Any patient liability other than the deductible or coinsurance/co-payment. This includes obligations for out-of-network care (balance billing), non-covered services, or penalties.
(i.e., no decimals).

**** Note: The sum of patient deductible, patient coinsurance/co-payment, and other patient obligations should equal total patient liability for the service.***

Reimbursement Amount: The amount paid to a practitioner, other health professional, or office facility. Each line item on the claim should have a reimbursement amount rounded to whole dollars **(i.e., no decimals).**

Billing and Reimbursement Information

PHARMACY FILE

Each of the following financial fields must be recorded by line item. The value of the financial field **must be represented using two implied decimal places. Use two zeros if cents are not provided.** Financial information includes:

(Note: **Patient Liability** has been replaced with three new financial data elements: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**.)

Financial information includes:

- Billed Charge
- Reimbursement Amount
- Patient Deductible **NEW!**
- Coinsurance/Co-payment **NEW!**
- Other Patient Obligations **NEW!**

All financials should be either numeric format (ASCII or EBCDIC) or signed overpunch. The financial **format** must be consistent for all financial fields.

Examples of **text format** which **must** be consistent for all financial fields include:

- 1997
- 1998
- 1999
- - 1997
- - 1998
- - 1999

Examples of **signed overpunch format** which ***must*** be consistent for all financial fields include:

POSITIVE

- 199{ = 1990
- 199A = 1991
- 199B = 1992
- 199C = 1993
- 199D = 1994
- 199E = 1995
- 199F = 1996
- 199G = 1997
- 199H = 1998
- 199I = 1999

NEGATIVE

- 199{ = **-**1990
- 199J = **-**1991
- 199K = **-**1992
- 199L = **-**1993
- 199M = **-**1994
- 199N = **-**1995
- 199O = **-**1996
- 199P = **-**1997
- 199Q = **-**1998
- 199R = **-**1999

PHARMACY FINANCIAL INFORMATION GLOSSARY

Line Item: A single line entry on a **PRESCRIPTION SERVICE**. The line item contains information on each **PRESCRIPTION** filled, including date filled, drug quantity and supply. This line item also includes billed charge, patient liability, and reimbursement amount for each prescription.

Billed Charge: PRESCRIPTION retail price including ingredient cost, dispensing fee, tax, and administrative expenditures. **Each line item of a prescription service must include the billed charge formatted USING 2 IMPLIED DECIMAL POINTS.**

Patient Deductible: The fixed amount that the patient must pay for covered medical services before benefits are payable.
Patient Coinsurance/Co-payment: The specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.
Other Patient Obligations: Any patient liability other than the deductible or coinsurance/co-payment. This includes obligations for out-of-network care (balance billing), non-covered services, or penalties.
Each line item of a prescription service must include these financial fields formatted USING 2 IMPLIED DECIMAL POINTS.

Note: The sum of patient deductible, patient coinsurance/co-payment, and other patient obligations should equal total patient liability for the service .

Reimbursement Amount: The amount paid to the pharmacy by the payer. **Each line item of a prescription service must include the reimbursement amount USING 2 IMPLIED DECIMAL POINTS**.

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Section IV

DATA ELEMENT DOCUMENTATION

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Coverage Type

Coverage Type: The data field that indicates type of insurance coverage (i.e., individual market, Medigap, employer sponsored, etc.).

Instructions: Please identify enrollee type of insurance coverage as mapped to the COMAR defined coverage types **AND** indicate the number of services in your data set.

(See Appendix E for plans that offer coverage in the various markets.)

Coverage Type MODIFIED!	**Value**	**Description** (describe values mapped from payer system)	**# Services**
Medicare Supplemental (i.e. Individual, Group, WRAP)	1		
Medicare Advantage Plan (Health plan options that are part of the Medicare program)	2		
Individual Market (not MHIP)	3		
Maryland Health Insurance Plan (MHIP) (State-managed health insurance program for MD residents unable to obtain health insurance from other sources.)	4		
Private Employer Sponsored or Other Group (i.e. union or association plans)	5		
Public Employee – Federal (FEHBP)	6		
Public Employee – Other (state, county, local/municipal government and public school systems)	7		
Comprehensive Standard Health Benefit Plan – (except HIP) (Private or Public Employee) The CSHBP applies to small businesses (i.e., public or private employers) with 2 to 50 eligible employees or a self-employed individual.	8		
Health Insurance Partnership (HIP) (State-subsidy to help MD small employers with 2-9 employees offer health insurance to their employees.)	9		
Unknown	Z		

Plan Liability Flag NEW!

Plan Liability Flag: This field indicates if the insurer is at risk for the patient's service use or the insurer is simply paying claims as an ASO (Administrative Services Only).

Plan Liability Flag		# Services
Risk	1	
ASO (employer self-insured)	2	
TOTAL		

Participating Provider Flag

Participating Provider Flag: This field identifies if the service was provided by a provider that participates in the payer's network. Please document why you cannot identify whether a provider does or does not participate.

Participating Provider Flag		# Services
Participating	1	
Non-Participating	2	
Not Coded	3	
TOTAL		

Delivery System Type

Delivery System Type: The data field that indicates the payer's product line.

Instructions: Please identify how your product line is mapped to the COMAR defined delivery system types **AND** indicate the number of services in your data set.

COMAR delivery system types include:

Delivery System Types	Value	Description (describe values mapped from payer system)	# Services (see page 7)
HMO (non-Medicaid, includes Medicare Advantage Plan)	1		
PPO-POS *	2		
PPO or Other Managed Care	3		
Indemnity Care	4		
HMO-POS Rider	5		
EPO **	6		
Not Coded	9		

*** COMAR Definition: PPO-POS**

A PPO-POS is a Preferred Provider Organization (PPO) insurance product with a primary care provider (PCP) gatekeeper. Enrollees access the provider network after obtaining approval from the PCP or may access out of network services without PCP approval.

**** COMAR Definition: EPO**

An Exclusive Provider Organization (EPO) is a narrowly defined provider network in which insurance carriers cover only in-network services provided by providers within the EPO.

Consumer Directed Health Plan Indicator (0,1): A "1" indicates a Consumer Directed Health Plan alone or with Health Savings Account (HSA) or Health Resources Account (HRA).

Instructions: Please identify how your product line is mapped to this indicator **AND** indicate the number of services in your data set.

Consumer Directed Health Plan Indicator	Value	Description (describe values mapped from payer system)	# Services
No	0		
Yes	1		

Place of Service

Place of Service: The location where health care services are rendered. Definitions provided on pages 20 & 21.

Instructions: In the description column, please describe the values as mapped from your system **AND** indicate the number of services in your Professional Services data set.

CMS/HIPAA Information			
Place of Service	**Value**	**Description** (describe values mapped from payer system)	**# Services**
Provider's Office	11		
Patient's Home	12		
Assisted Living Facility	13		
Urgent Care Facility – please code appropriately	**20**		
Inpatient Hospital	21		
Outpatient Hospital	22		
Emergency Room – Hospital	23		
Ambulatory Surgical Center	24		
Birthing Center	25		
Military Treatment Facility	26		
Skilled Nursing Facility	31		
Nursing Facility	32		
Custodial Care Facility	33		
Hospice	34		
Ambulance – Land	41		
Ambulance – Air or Water	42		
Inpatient Psychiatric Facility	51		
Psychiatric Facility – Partial Hospitalization	52		
Community Mental Health Center	53		
Intermediate Care Facility/Mentally Retarded	54		
Residential Substance Abuse Treatment Facility	55		
Psychiatric Residential Treatment Center	56		
Non-residential Substance Abuse Treatment Facility	57		
Mass Immunization Center	60		
Comprehensive Inpatient Rehabilitation Facility	61		
Comprehensive Outpatient Rehabilitation Facility	62		
End-Stage Renal Disease Treatment Facility	65		
State or Local Public Health Clinic	71		
Rural Health Clinic	72		
Independent Laboratory & Imaging	81		
Other Place of Service	99		

Place of Service Codes for Professional Claims
Centers for Medicare & Medicaid Services

CMS – Code	Place of Service	Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility that provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance – Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52	Psychiatric Facility - Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

Practitioner Specialty

Practitioner Specialty: The health care field in which a physician, licensed health care professional, dental practitioner, or office facility has been certified.

Instructions: In the description column, please list the payer specialty description(s) mapped to the COMAR defined specialties (more than one specialty can map to a COMAR defined specialty). Please indicate the number of services in your Professional Services data set that link to those specialties in the Provider Directory file. (See Appendix D for examples of practitioner specialty expansions and/or consolidations.)

Physicians: (This list is not all inclusive.)

◆ **INDICATES SPECIALTY LISTED ALPHABETICALLY & NUMERICALLY.**

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
General Practice	001		
General Surgery	002		
Allergy & Immunology	003		
Anesthesiology	004		
Cardiology	005		
Dermatology	006		
Emergency Medicine	007		
Endocrinology Medicine	008		
Family Practice	009		
Gastroenterology	010		
Geriatrics	011		
Hand Surgery	012		
Hematology	013		
Internal Medicine	014		
Infectious Disease	015		
Multi-Specialty Medical Practice ◆	101		
Nephrology	016		
Neonatology ◆	100		
Neurology	017		
Nuclear Medicine	018		

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
Obstetrics/Gynecology ◆	039		
Oncology	019		
Ophthalmology	020		
Orthopedic Surgery	021		
Osteopathy (include Manipulations)	022		
Otology, Laryngology, Rhinology, Otolaryngology	023		
Pathology	024		
Pediatrics	025		
Peripheral Vascular Disease or Surgery	026		
Plastic Surgery	027		
Physical Medicine and Rehabilitation	028		
Proctology	029		
Psychiatry	030		
Pulmonary Disease	031		
Radiology	032		
Rheumatology	033		
Surgical Specialty Not Listed Here	034		
Thoracic Surgery	035		
Urology	036		
Other Specialties not listed (public health, industrial medicine)	037		
Physician w/o Specialty Identified & Specialty not listed here	038		
Obstetrics/Gynecology ◆	039		
Neonatology ◆	100		
Multi-Specialty Medical Practice ◆	101		

◆ **INDICATES SPECIALTY LISTED ALPHABETICALLY & NUMERICALLY.**

Other Health Care Professionals: (This list is not all inclusive.)

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
Acupuncturist	040		
Alcohol/Drug Detox Services	041		
Ambulance Services	042		
Audiologist/Speech Pathologist	043		
Chiropractor	044		
Freestanding Clinic (Not a Government Agency)	045		
Day Care Facility (Medical, Mental Health)	046		
Dietitian/Licensed Nutritionist	047		
Home Health Provider	048		
Mental Health Clinic ◆	102		
Advanced Practice Nurse: Anesthetist	049		
Advanced Practice Nurse: Midwife	050		
Advanced Practice Nurse: Nurse Practitioner	051		
Advanced Practice Nurse: Psychotherapist	052		
Nurse – Other than Advanced Practice	053		
Occupational Therapist	054		
Optometrist	055		
Podiatrist	056		
Physical Therapist	057		
Psychologist	058		
Clinical Social Worker	059		
Public Health or Welfare Agency (federal, state and local gov)	060		
Respiratory Therapist	063		
Voluntary Health Agency	061		
Other Specialty (Not Listed Above)	062		
Mental Health Clinic ◆	102		

◆ **INDICATES SPECIALTY LISTED ALPHABETICALLY & NUMERICALLY.**

Dental: (This list is not all inclusive.)

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
General Dentist	070		
Endodontist	071		
Orthodontist	072		
Oral Surgeon	073		
Pedodontist	074		
Periodontist	075		
Prosthodontist	076		

Office Facilities: (This list is not all inclusive.)

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
Freestanding Pharmacy (includes grocery stores)	080		
Mail Order Pharmacy	081		
Independent Laboratory	082		
Independent Medical Supply Company	083		
Optician/Optometrist (for lenses and eye glasses)	084		
Please specify whether using professional services or supplier codes for the following:			
All Other Supplies	085		
Freestanding Medical Facility	090		
Freestanding Surgical Facility	091		
Freestanding Imaging Center	092		
Other Facility	093		

Type of Bill

Type of Bill: The data field that describes payment and adjustment status.

NOTE: Capitated services on the Professional Services File are also identified as services where at least three financial variables (billed charge, allowed amount, and reimbursement amount) are equal to **–999**.

MUST SUBMIT IN REQUIRED FORMAT *(see below)*

Value	Label	Definition
1	**Final Bill**	Total adjusted amount of all credits and debits paid for a claim by the insurance company to the provider.
8	**Capitated Services**	Set of pre-defined services provided by the provider to the plan's enrollees under contract with an insurance company or managed care plan in exchange for a fixed and guaranteed monthly payment for each enrollee assigned to the provider.

Instructions: Identify type of bill in the column provided. Please indicate the number of services in your data set.

Type of Bill Description	# Services
1 – Final Bill	
8 – Capitated Services	

MARYLAND HEALTH CARE COMMISSION

Appendix A

FILE LAYOUTS

- Professional Services Data Report
- Pharmacy Data Report
- Provider Directory Report

Formatted for 2008 MCDB data due June 30, 2009

File Layout

Professional Services Data Report Submission

This report details fee-for-service and specialty-care capitated encounters provided by health care practitioners and office facilities from **January 1, 2008 through April 30, 2009**. Please provide information on all health care services provided to Maryland residents whether provided by a practitioner or office facility located in-state or out-of-state.

(Note: **Patient Liability** has been replaced with three new financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**.)

COMAR specifies that the Professional Services Data Report file layout can be either fixed or variable. The two file layouts are as follows:

Option 1, FIXED FORMAT: (preferred)
Using the fixed format, it is possible that multiple services will be reported for each claim. Count each reported health care service even though documented on a single claim. The number of line items will always equal one (1) because one service is written per row.

FIXED FORMAT

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End
1.	Patient ID (encrypted)	12	A		1	12
2.	Patient Date of Birth (CCYYMM00)	8	N		13	20
3.	Patient Sex	1	N		21	21
4.	Consumer Directed Health Plan (CDHP) alone or w/ HSA or HRA indicator	1	N		22	22
5.	Patient Zip Code	5	N		23	27
6.	Patient Covered by Other Insurance	1	N		28	28
7.	Coverage Type (This field must be mapped –see pg. 16)	1	A		29	29
8.	Delivery System Type (this field must be mapped –see pg. 18)	1	N		30	30
9.	Claim Related Condition	1	N		31	31
10.	Practitioner Federal Tax ID	9	A		32	40
11.	Participating Provider Flag	1	N		41	41
12.	Type of Bill (This field must be mapped –see pg. 26)	1	A		42	42
13.	Claim Control Number (Include on each record as this is the key to summarizing service detail to claim level)	23	A		43	65
14.	Claim Paid Date (CCYYMMDD)	8	N		66	73
15.	Number of Diagnosis Codes	2	N		74	75
16.	Number of Line Items (always **= 01** for fixed format – see pg. 37)	2	N		76	77
17.	Diagnosis Code 1 - **Remove imbedded decimal points**	5	A		78	82
18.	Diagnosis Code 2	5	A		83	87
19.	Diagnosis Code 3	5	A		88	92
20.	Diagnosis Code 4	5	A		93	97

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End
21.	Diagnosis Code 5	5	A		98	102
22.	Diagnosis Code 6	5	A		103	107
23.	Diagnosis Code 7	5	A		108	112
24.	Diagnosis Code 8	5	A		113	117
25.	Diagnosis Code 9	5	A		118	122
26.	Diagnosis Code 10	5	A		123	127
27.	Service From Date (CCYYMMDD)	8	N		128	135
28.	Service Thru Date (CCYYMMDD)	8	N		136	143
29.	Filler	2			Blank (144)	Blank (145)
30.	Place of Service	2	N		146	147
31.	Service Location Zip Code	5	A		148	152
32.	Service Unit Indicator	1	N		153	153
33.	Units of Service	3	N	1 implied*	154	156
34.	Procedure Code	6	A		157	162
35.	Modifier I (this field must be mapped –see pg. 39)	2	A		163	164
36.	Modifier II (specific to Modifier I)	2	A		165	166
37.	Servicing Practitioner ID	11	A		167	177
38.	Billed Charge (line item amounts required – see pg. 13)	9	N		178	186
39.	Allowed Amount (line item amounts required – see pg. 13)	9	N		187	195
40.	Reimbursement Amount (line item amounts required – see pg. 13)	9	N		196	204
41.	Date of Enrollment	8	N		205	212
42.	Date of Disenrollment	8	N		213	220
43.	**Patient Deductible** **NEW!** (line item amounts required– see pg. 13)	9	N		221	229
44.	**Patient Coinsurance** or **Patient Co-payment** **NEW!** (line item amounts required– see pg. 13)	9	N		230	238
45.	**Other Patient Obligations** **NEW!** (line item amounts required– see pg. 13)	9	N		239	247
46.	**Plan Liability** **NEW!**	1	N		248	248
47.	**National Provider Identifier** **NEW!** (Servicing Practitioner NPI #)	10	A		249	258

* Implied decimal should only be used for anesthesia time units; all other units should be submitted as integers.

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

The Professional Services data must link to the Pharmacy data by Patient ID.

Encryption of Patient ID must be consistent with encryption of Patient ID in Pharmacy File.

MHCC will return files that do not link.

Professional Services Data Report Submission

Option 2, VARIABLE FORMAT: Count each reported service as a health care claim even though the claim may contain multiple services. For example, if a claim documents three (3) services then three (3) occurrences in the line item section must be reported.

(Note: **Patient Liability** has been replaced with three new financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**.)

VARIABLE FORMAT

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Occurs	Start	End
1.	Patient ID (encrypted)	12	A			1	12
2.	Patient Date of Birth (CCYYMM00)	8	N			13	20
3.	Patient Sex	1	N			21	21
4.	Consumer Directed Health Plan (CDHP) alone or w/ HSA or HRA indicator	1	N			22	22
5.	Patient Zip Code	5	N			23	27
6.	Patient Covered by Other Insurance	1	N			28	28
7.	Coverage Type (This field must be mapped –see pg. 16)	1	A			29	29
8.	Delivery System Type (This field must be mapped –see pg. 18)	1	N			30	30
9.	Claim Related Condition	1	N			31	31
10.	Practitioner Federal Tax ID	9	A			32	40
11.	Participating Provider Flag	1	N			41	41
12.	Type of Bill (This field must be mapped –see pg. 26)	1	A			42	42
13.	Claim Control Number (This is the key to summarizing service detail to claim level & must be included on each record.)	23	A			43	65
14.	Claim Paid Date (CCYYMMDD)	8	N			66	73
15.	Date of Enrollment	8	N			74	81
16.	Date of Disenrollment	8	N			82	89
17.	Number of Line Items (see pg. 37 for clarification)	2	N			90	91
▶	**Items 18-38 represent line items only. Repeat format 18-38 for each additional line item.**	122			26	92	
18.	Number of Diagnosis Codes	2	N				
19.	Diagnosis (Field will hold up to 10 diagnosis codes. Leave fields blank if not available.) **Remove imbedded decimal points**	5	A		10		
20.	Service From Date (CCYYMMDD)	8	N				
21.	Service Thru Date (CCYYMMDD)	8	N				
22.	Filler	2				blank	blank
23.	Place of Service	2	N				
24.	Service Location Zip Code	5	A				

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Occurs	Start	End
25.	Service Unit Indicator	1	N				
26.	Units of Service	3	N	1 implied*			
27.	Procedure Code	6	A				
28.	Modifier I (this field must be mapped – see pg. 39)	2	A				
29.	Modifier II (specific to Modifier I)	2	A				
30.	Servicing Practitioner ID	11	A				
31.	Billed Charge (line item amounts required – see pg. 13)	9	N				
32.	Allowed Amount (line item amounts required – see pg. 13)	9	N				
33.	Reimbursement Amount (line item amounts required – see pg. 13)	9	N				
34.	**Patient Deductible** **NEW!** (line item amounts required– see pg. 13)	9	N				
35.	**Patient Coinsurance** or **Patient Co-payment** **NEW!** (line item amounts required– see pg. 13)	9	N				
36.	**Other Patient Obligations** **NEW!** (line item amounts required– see pg. 13)	9	N				
37.	**Plan Liability** **NEW!**	1	N				
38.	**National Provider Identifier** **NEW!** (Servicing Practitioner NPI #)	10	A				

* Implied decimal should only be used for anesthesia time units; all other units should be submitted as integers.

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

The Professional Services data must link to Pharmacy data by Patient ID.

Encryption of Patient ID must be consistent with encryption of Patient ID in Pharmacy File.

MHCC will return files that do not link.

File Layout

Pharmacy Data Report Submission

This report details all prescription drug encounters for your enrollees **filled from January 1, 2008 through April 30, 2009.** Please provide information on all prescription drugs provided to Maryland residents whether provided by a pharmacy located in-state or out-of-state. **Do not include pharmacy supplies or prosthetics. COMAR specifies the Pharmacy Report be submitted separately from the Professional Services Report.**

(Note: **Patient Liability** has been replaced with three new financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**.)

Fixed Format

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End
1.	Patient ID (encrypted)	12	A		1	12
2.	Patient Sex	1	N		13	13
3.	Patient Zip Code	5	N		14	18
4.	Patient Date of Birth (CCYYMM00)	8	N		19	26
5.	Pharmacy NCPDP Number **(left justified)**	7	N		27	33
6.	Pharmacy Zip Code (location where prescription was filled and dispensed)	5	N		34	38
7.	Practitioner DEA # (left justified; for many payers the last 2 positions on the right will be blank)*	11	A		39	49
8.	NDC Code	11	N		50	60
9.	Drug Compound	1	N		61	61
10.	Drug Quantity	5	N		62	66
11.	Drug Supply	3	N		67	69
12.	Date Filled (CCYYMMDD)	8	N		70	77
13.	Billed Charge (line item amounts required – see pg. 14)	9	N	2	78	86
14.	Reimbursement Amount (line item amounts required – see pg. 14)	9	N	2	87	95
15.	**Prescription Claim Number**	15	N		96	110
16.	**National Provider Identifier** **NEW!** (Prescribing Practitioner NPI #)	10	A		111	120
17.	**Patient Deductible** **NEW!** (line item amounts required – see pg. 14)	9	N	2	121	129
18.	**Patient Coinsurance** or **Patient Co-payment** **NEW!** (line item amounts required – see pg. 14)	9	N	2	130	138
19.	**Other Patient Obligations** **NEW!** (line item amounts required – see pg. 14)	9	N	2	139	147

*** Please note which of the following you are using to link the Pharmacy Data Report with the Provider Directory Report:**

☐ DEA (Drug Enforcement Agency) # ☐ Other (exception waiver from MHCC required)

The Pharmacy data must link to Professional Services data by Patient ID.

Encryption of Patient ID must be consistent with encryption of Patient ID in Professional Services File.

File Layout

Provider Directory Report Submission

This report details all health care practitioners (including other health care professionals, dental/vision services covered under a medical plan, and office facilities) who provided services to your enrollees from **January 1, 2008 through April 30, 2009**.

MODIFIED! File Layout for the Provider Directory Report is a 121 byte **fixed format.** The file layout is as follows:

	Field Name	Length	Type A= Alphanumeric	Dec	Start	End
1.	Servicing Practitioner ID	11	A		1	11
2.	Practitioner Federal Tax ID	9	A		12	20
3.	Practitioner Last Name or Multi-practitioner Health Care Organization Truncate if over 31 characters	31	A		21	51
4.	Practitioner First Name	19	A		52	70
5.	Practitioner Middle Initial	1	A		71	71
6.	Practitioner Name Suffix	4	A		72	75
7.	Practitioner Credential	5	A		76	80
8.	Practitioner Specialty – 1	3	A		81	83
9.	Practitioner Specialty – 2	3	A		84	86
10.	Practitioner Specialty – 3	3	A		87	89
11.	Practitioner DEA #	11	A		90	100
12.	Indicator for multi-practitioner health care organization	1	A		101	101
13.	**National Provider Identifier** (Servicing Practitioner NPI #)	10	A		102	111
14.	**Maryland Health Professional License Number**	10	A		112	121

REMINDERS !!!

- **It is mandatory to separate all of the name components and provide them in the positions listed in the table above.**
- **Include information on in-state practitioners as well as those out-of-state who served Maryland residents.**
- **Use specific (separate) fields for practitioner First Name and Last Name.**
- **Confirm SERVICING PRACTITIONER ID # matches SERVICING PRACTITIONER ID # in Professional Services File Layout.**
- **Confirm practitioner DEA #s match Pharmacy File DEA #s.**

Appendix B

MEDIA FORMAT INFORMATION

Instructions: MHCC will permit payers to upload data to a **Secure FTP server**, provided they have a **Secure FTP client**. This is the preferred submission method. If you would like to use this submission option, please contact Larry Monroe at (410) 764-3390 or via e-mail at lmonroe@mhcc.state.md.us. Otherwise data must be provided on one of the following media using either the ASCII or EBCDIC recording format. **Please label all media & documentation with your Payer ID # (pg. 52).**

CD-ROM/DVD

Record Type:	Fixed (preferred) or Variable length records
Recording Format:	ASCII or EBCDIC

IBM 3480/3480E or 3490/3490E Cartridge

Block Size:	16,000 bytes minimum, 32,760 bytes maximum
Record Type:	Fixed (preferred) or Variable length records
Recording Format:	ASCII or EBCDIC
Labels:	Standard IBM labels preferred
Media:	3480/3480E or 3490/3490E Cartridge
Density:	3480/3480E or 3490/3490E Cartridge – default density

DLT Tape IV

Block Size:	16,000 bytes minimum, 32,760 bytes maximum
Record Type:	Fixed (preferred) or Variable length records
Recording Format:	ASCII or EBCDIC
Media:	DLT using dd or TAR commands
Density:	1600 BPI

MARYLAND HEALTH CARE COMMISSION

Appendix C

DATA DICTIONARY

- Professional Services Data Report
- Pharmacy Data Report
- Provider Directory Report

Formatted For 2008 MCDB data due June 30, 2009

Data Dictionary – PROFESSIONAL SERVICES

Field Name	COMAR	Description	Field Contents
Patient ID	10.25.06.06.D1	Patient's unique identification number, assigned by the payer and encrypted.	
Patient Date of Birth	10.25.06.06.D2	Date of patient's birth using 00 instead of day.	CCYYMM00
Patient Sex	10.25.06.06.D3	Sex of the patient.	1 Male 2 Female 3 Unknown
Consumer Directed Health Plan (CDHP) alone or w/ HSA or HRA Indicator		Consumer Directed Health Plan (CDHP) alone or with Health Savings Account (HSA) or Health Resources Account (HRA)	0 No 1 Yes
Patient Zip Code	10.25.06.06.D5	Zip code of patient's residence.	
Patient Covered by Other Insurance	10.25.06.06.D6	Indicates whether patient has additional insurance coverage.	0 No 1 Yes, other coverage is primary 2 Yes, other coverage is secondary 9 Unknown
Coverage Type **MODIFIED!**	10.25.06.06.D7	Patient's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not MHIP) 4 Maryland Health Insurance Plan (MHIP) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 8 Comprehensive Standard Health Benefit Plan (a self employed individual or small businesses (public or private employers) with 2-50 eligible employees) 9 Health Insurance Partnership (HIP) Z Unknown
Delivery System Type	10.25.06.06.D8	Type of delivery system rendering service.	1 HMO (non-Medicaid, includes Medicare) 2 PPO-POS 3 PPO or Other Managed Care 4 Indemnity Care 5 HMO-POS Rider **6 EPO** 9 Unknown – Not Coded

Field Name	COMAR	Description	Field Contents
Claim Related Condition	10.25.06.06.D9	Describes connection, if any, between patient's condition and employment, automobile accident, or other accident.	0 Non-accident (default) 1 Work 2 Auto Accident 3 Other Accident 9 Unknown
Practitioner Federal Tax ID	10.25.06.06.D10	Employer Tax ID of the practitioner, practice or office facility receiving payment for services.	
Participating Provider Flag	10.25.06.06.D11	Indicates if the service was provided by a provider that participates in the payer's network.	1 Participating 2 Non-Participating 3 Unknown/Not Coded
Type of Bill	10.25.06.06.D12	Describes payment and adjustment status of a claim. Adjustments include paying a claim more than once, paying additional services that may have been denied, or crediting a provider due to overpayment or paying the wrong provider.	1 Final Bill 8 Capitated Services
Claim Control Number	10.25.06.06.D13	Internal payer claim number used for tracking.	
Claim Paid Date	10.25.06.06.D14	The date a claim was authorized for payment.	CCYYMMDD
Number of Diagnosis Codes	10.25.06.06.D15	The number of diagnosis codes, up to ten.	1 through 10. Maximum is 10.
Number of Line Items	10.25.06.06.D16	If using **Variable Format**, the # of line items completed in the variable portion (data elements 18-38) must match the value entered for this data element, maximum value for this data and # of line items is 26. If using **Fixed Format**, the number of line items is always equal to one (1) because only one service is written per row.	
Diagnosis Codes	10.25.06.06.D17-D26	The primary ICD-9-CM Diagnosis Code followed by a secondary diagnosis (up to 9 codes), if applicable at time of service. **Remove imbedded decimal point**	
Service From Date	10.25.06.06.D27	First date of service for a procedure in this line item.	CCYYMMDD
Service Thru Date	10.25.06.06.D28	Last date of service for this line item.	CCYYMMDD

Field Name	COMAR	Description	Field Contents
Place of Service	10.25.06.06.D21	Two-digit numeric code that describes where a service was rendered.	**CMS: (definitions listed on pages 18 - 19)** 11 Provider's Office 12 Patient's Home 13 Assisted Living Facility 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – Land 42 Ambulance – Air or Water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 57 Non-residential Substance Abuse Treatment Facility 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory & Imaging 99 Other Place of Service
Service Location Zip Code	10.25.06.06.D22	Zip code for location where service described was provided.	
Service Unit Indicator	10.25.06.06.D23	Category of service as it corresponds to Units data element.	0 Values reported as zero (no allowed services) 1 Transportation (ambulance air or ground) Miles 2 Anesthesia Time Units 3 Services 4 Oxygen Units 5 Units of Blood 6 Allergy Tests **7 Lab Tests** 8 Minutes of Anesthesia (waiver required)

Field Name	COMAR	Description	Field Contents
Units of Service	10.25.06.06.D24	Quantity of services or number of units for a service or minutes of anesthesia.	One (1) implied decimal for anesthesia time units; all other units submit as integers.
Procedure Code	10.25.06.06.D25	Describes the health care service provided (i.e., CPT-4, HCPCS or Homegrown).	
Modifier I	10.25.06.06.D26	Discriminate code used by practitioners to distinguish that a health care service has been altered [by a specific condition] but not changed in definition or code. A modifier is added as a suffix to a procedure code field.	MHCC accepts national standard modifiers approved by the American Medical Association as published in the 2004 Current Procedure Terminology. Modifiers approved for Hospital Outpatient use: Level I (CPT) and Level II (HCPCS/National) modifiers. Nurse Anesthetist services are to be reported using the following Level II (HCPCS) modifiers: • **QX** – Nurse Anesthetist service; under supervision of a doctor • **QZ** – Nurse Anesthetist service; w/o the supervision of a doctor
Modifier II	10.25.06.06.D27	Specific to Modifier I.	
Servicing Practitioner ID	10.25.06.06.D28	Payer-specific identifier for the practitioner rendering health care service(s).	
Billed Charge	10.25.06.06.D29	A practitioner's billed charges rounded to whole dollars. **DO NOT USE DECIMALS**	
Allowed Amount	10.25.06.06.D30	Total patient and payer liability. **DO NOT USE DECIMALS**	
Reimbursement Amount	10.25.06.06.D31	Amount paid to Employer Tax ID # of rendering physician as listed on claim. **DO NOT USE DECIMALS**	
Patient Liability (Replaced with Patient Deductible, Patient Coinsurance/Co-payment, and Other Patient Obligations see below)	10.25.06.06.D32	Patient Liability field has been replaced with 3 new financial fields: Patient Deductible, Patient Coinsurance/Co-payment, and Other Patient Obligations (File extended)	
Date of Enrollment		The start date of enrollment for the patient in this delivery system (in this data submission time period). (See Delivery System Type on page 36)	CCYYMMDD Date is 20080101 if patient is enrolled at start of 2008. Enter other date if patient **not enrolled** at start of year, enrolled during 2008.
Date of Disenrollment		The end date of enrollment for the patient in this delivery system (in this data submission time period). (See Delivery System Type on page 36)	CCYYMMDD **Leave blank** if patient is still enrolled on 20081231. If patient disenrolled before end of year enter date disenrolled.

Field Name	COMAR	Description	Field Contents
Patient Deductible **NEW!**	10.25.06.06.D32	The fixed amount that the patient must pay for covered medical services before benefits are payable. **DO NOT USE DECIMALS**	
Patient Coinsurance/ Co-payment **NEW!**	10.25.06.06.D32	The specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible. **DO NOT USE DECIMALS**	
Other Patient Obligations **NEW!**	10.25.06.06.D32	Any patient liability other than the deductible or coinsurance/co-payment. This includes obligations for out-of-network care (balance billing), non-covered services, or penalties. **DO NOT USE DECIMALS**	
Plan Liability **NEW!**		Indicates if insurer is at risk for the patient's service use or the insurer is simply paying claims as Administrative Services Only (ASO)	1 Risk 2 ASO (employer self-insured)
National Provider Identifier # **NEW!** (Servicing Practitioner NPI #)		Federal identifier for health care providers used in all HIPAA transactions.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf

Data Dictionary – PHARMACY

Field Name	COMAR	Description	Field Contents
Patient ID	10.25.06.07.C1	Patient's unique identification number, assigned by the payer and encrypted.	
Patient Sex	10.25.06.07.C2	Sex of Patient.	1 Male 2 Female 3 Unknown
Patient Zip Code	10.25.06.07.C3	Zip code of patient's residence.	
Patient Date of Birth	10.25.06.07.C4	Date of patient's birth using 00 instead of day.	CCYYMM00
Pharmacy NCPDP Number	10.25.06.07.C5	Unique 7 digit number assigned by the National Council for Prescription Drug Program (NCPDP).	
Pharmacy Zip Code	10.25.06.07.C6	Zip code of pharmacy where prescription was dispensed.	
DEA #	10.25.06.07.C7	Drug Enforcement Agency number assigned to an individual registered under the Controlled Substance Act.	Same as DEA # in Provider File.
NDC Code	10.25.06.07.C9	National Drug Code 11 digit number.	
Drug Compound	10.25.06.07.C10	Indicates a mix of drugs to form a compound medication.	1 Non-compound 2 Compound
Drug Quantity	10.25.06.07.C11	Number of units dispensed.	
Drug Supply	10.25.06.07.C12	Estimated number of days of dispensed supply.	
Date Filled	10.25.06.07.C13	Date prescription filled.	CCYYMMDD
Patient Liability (Replaced with Patient Deductible, Patient Coinsurance/Co-payment, and Other Patient Obligations - see below)	10.25.06.07.C14	Patient Liability field has been replaced with 3 new financial fields: Patient Deductible, Patient Coinsurance/Co-payment, and Other Patient Obligations (File extended)	
Billed Charge	10.25.06.07.C15	Retail amount for drug including dispensing fees and administrative costs. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Reimbursement Amount	10.25.06.07.C16	Amount paid to the pharmacy by payer. Do not include patient copayment or sales tax. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	

Field Name	COMAR	Description	Field Contents
Prescription Claim Number **NEW!**		Internal payer claim number used for tracking.	A credit should have the same claim number as the original debit record.
National Provider Identifier # **NEW!** (Prescribing Practitioner NPI #)		Federal identifier for health care providers used in all HIPAA transactions.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Patient Deductible **NEW!**	10.25.06.07.C14	The fixed amount that the patient must pay for covered medical services before benefits are payable. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Patient Coinsurance/ Co-payment **NEW!**	10.25.06.07.C14	The specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Other Patient Obligations **NEW!**	10.25.06.07.C14	Any patient liability other than the deductible or coinsurance/co-payment. This includes obligations for out-of-network care (balance billing), non-covered services, or penalties.. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	

Data Dictionary – PROVIDER

Field Name	COMAR	Description	Field Contents
Servicing Practitioner ID	10.25.06.08.D1	Payer-specific identifier for a practitioner, practice, or office facility rendering health care service(s).	
Practitioner Federal Tax ID	10.25.06.08.D2	Employer Tax ID # of the practitioner, practice or office facility receiving payment for services.	Same as Federal Tax ID # in Professional Services File.
Practitioner Last Name or Multi-practitioner Health Care Organization	10.25.06.08.D3	Last name of practitioner or complete name of multi-practitioner health care organization.	**Please truncate if name of practitioner or medical organization exceeds 31 characters.**
Practitioner First Name	10.25.06.08.D4	Practitioner's first name.	Individual provider's first name.
Practitioner Middle Initial			First letter of individual provider's middle name.
Practitioner Name Suffix			Individual provider's name suffix, such as Jr., Sr., II, III, IV, or V.
Practitioner Credential			Abbreviations for professional degrees or credentials used or held by an individual provider, such as MD, DDS, CSW, CNA, AA, NP, PSY.
Practitioner Specialty	10.25.06.08.D5	The health care field in which a physician, licensed health care professional, dental practitioner, or office facility has been certified. Up to 3 codes may be listed.	**Physicians:** 001 General Practice 002 General Surgery 003 Allergy & Immunology 004 Anesthesiology 005 Cardiology 006 Dermatology 007 Emergency Medicine 008 Endocrinology Medicine 009 Family Practice 010 Gastroenterology 011 Geriatrics 012 Hand Surgery 013 Hematology 014 Internal Medicine 015 Infectious Disease 101 Multi-Specialty Medical Practice

Field Name	COMAR	Description	Field Contents
Practitioner Specialty (con't.)			016 Nephrology 100 Neonatology 017 Neurology 018 Nuclear Medicine 039 Obstetrics/Gynecology 019 Oncology 020 Ophthalmology 021 Orthopedic Surgery 022 Osteopathy (includes manipulations) 023 Otology, Laryngology, Rhinology, Otolaryngology 024 Pathology 025 Pediatrics 026 Peripheral Vascular Disease or Surgery 027 Plastic Surgery 028 Physical Medicine and Rehabilitation 029 Proctology 030 Psychiatry 031 Pulmonary Disease 032 Radiology 033 Rheumatology 034 Surgical Specialty Not Listed Here 035 Thoracic Surgery 036 Urology 037 Other Spec Not Listed (public health,industrial medicine) 038 Phys w/o Spec Identified & Spec Not Listed 039 Obstetrics/Gynecology **Other Health Care Professionals:** 040 Acupuncturist 041 Alcohol/Drug Detox Services 042 Ambulance Services 043 Audiologist/Speech Pathologist 044 Chiropractor 045 Freestanding Clinic – Not a Government Agency 046 Day Care Facility: Medical, Mental Health 047 Dietitian/Licensed Nutritionist 048 Home Health Provider 102 Mental Health Clinic 049 Advanced Practice Nurse: Anesthetist 050 Advanced Practice Nurse: Midwife 051 Advanced Practice Nurse: Nurse Practitioner 052 Advanced Practice Nurse: Psychotherapist 053 Nurse – Other Than Advanced Practice 054 Occupational Therapist 055 Optometrist 056 Podiatrist

Field Name	COMAR	Description	Field Contents
Practitioner Specialty (con't.)			057 Physical Therapist 058 Psychologist 059 Clinical Social Worker 060 Public Health or Welfare Agency (federal, state, and local government) 061 Voluntary Health Agency 062 Other Specialty Not Listed Above 063 Respiratory Therapist **Dental:** 070 General Dentist 071 Endodontist 072 Orthodontist 073 Oral Surgeon 074 Pedodontist 075 Periodontist 076 Prosthodontist **Office Facilities:** 080 Freestanding Pharmacy (includes grocery) 081 Mail Order Pharmacy 082 Independent Laboratory 083 Independent Medical Supply Company 084 Optician/Optometrist (for lenses & eye glasses) 085 All Other Supplies 090 Freestanding Medical Facility 091 Freestanding Surgical Facility 092 Freestanding Imaging Center 093 Other facility
DEA #	10.25.06.08.D6	Drug Enforcement Agency number assigned to an individual registered under the Controlled Substance Act.	Same as DEA# in Pharmacy File.
Indicator for multi-physician health care organization			0 Solo Practitioner 1 Multiple Practitioners
National Provider Identifier # (Servicing Practitioner NPI #)		Federal identifier for health care providers used in all HIPAA transactions.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Maryland Health Professional License Number			Ten (10) digits

MARYLAND HEALTH CARE COMMISSION

Appendix D

Explanation of

PRACTITIONER SPECIALTY

Formatted for 2008 MCDB data due June 30, 2009

Practitioner Specialty Expansions/Consolidations

Practitioner Specialty: The health care field in which a physician, licensed health care professional, dental practitioner, or office facility has been certified. **The following table shows examples where a practitioner specialty may encompass other services and is for illustrative purposes only.**

This list is <u>not</u> all inclusive.

Practitioner Specialty	Value	Specialties Not Specifically Identified
General Practice	001	
General Surgery	002	
Allergy & Immunology	003	Pediatric Allergy & Immunology
Anesthesiology	004	
Cardiology	005	Pediatric Cardiology
Dermatology	006	Dermatopathology
Emergency Medicine	007	
Endocrinology Medicine	008	Pediatric Endocrinology
Family Practice	009	
Gastroenterology	010	Pediatric Gastroenterology
Geriatrics	011	
Hand Surgery	012	
Hematology	013	Pediatric Hematology/Oncology
Internal Medicine	014	Adolescent Medicine
Infectious Disease	015	Pediatric Infectious Disease
Multi-Specialty Medical Practice	101	Use this code only where provider-specific identifiers are not available for physicians practicing as a group with varying specialties.
Nephrology	016	Pediatric Nephrology
Neonatology	100	
Neurology	017	Pediatric Neurology
Nuclear Medicine	018	
Obstetrics/Gynecology	039	
Oncology	019	Gynecological Oncology
Ophthalmology	020	Pediatric Ophthalmology
Orthopedic Surgery	021	Pediatric Orthopedic Surgery
Osteopathy	022	Include manipulations
Otology, Laryngology, Rhinology, Otolaryngology	023	
Pathology	024	Forensic Pathology Oral Pathology
Pediatrics	025	
Peripheral Vascular Disease/Surgery	026	
Plastic Surgery	027	Reconstructive Surgery Cosmetic Surgery
Physical Medicine and Rehabilitation	028	Rehabilitative Sports Medicine
Proctology	029	Colon & Rectal Surgery
Psychiatry	030	Pediatric Psychiatry
Pulmonary Disease	031	Pediatric Pulmonary Medicine
Radiology	032	MRI Nuclear Radiology Pediatric Radiology

Practitioner Specialty	Value	Specialties Not Specifically Identified	
Rheumatology	033		
Surgical Specialty Not Listed Here	034	Abdominal Surgery Head and Neck Surgery Maxillofacial Surgery	Neurological Surgery Pediatric Surgery Vascular Surgery
Thoracic Surgery	035	Cardiovascular Surgery Thoracic Surgery	
Urology	036	Urology Pediatric Urology	
Other Specialties Not Listed	037	Public Health Industrial Medicine	
Physician without a Specialty Identified and Specialty Not Listed Here	038	• Addiction Medicine • Algology/Pain Management • Aerospace Medicine • Critical Care Medicine • Genetics • Infertility	• Multiple Specialty Physician Group • Occupational Medicine • Preventative Medicine • Reproductive Endocrinology • Urgent Care Medicine

Other Health Care Professionals: (This list is <u>not</u> all inclusive.)

Practitioner Specialty	Value	Other Services Included
Acupuncturist	040	
Alcohol/Drug Detox Services	041	
Ambulance Services	042	
Audiologist/Speech Pathologist	043	
Chiropractor	044	
Freestanding Clinic (Not a Government Agency)	045	
Day Care Facility	046	Medical Mental Health
Dietitian/Licensed Nutritionist	047	
Home Health Provider	048	Home Infusion Therapy
Mental Health	102	Use this code only where provider-specific identifiers are not available for facilities where mental health services are provided by a psychiatrist, psychologist, or social worker.
Advanced Practice Nurse: Anesthetist	049	Nurse Anesthetist/Certified Registered Nurse Anesthetist (CRNA)
Advanced Practice Nurse: Midwife	050	Nurse Midwife
Advanced Practice Nurse: Nurse Practitioner	051	Nurse Practitioner
Advanced Practice Nurse: Psychotherapist	052	Nurse Psychotherapist
Nurse – Other than Advanced Practice	053	
Occupational Therapist	054	
Optometrist	055	
Podiatrist	056	
Physical Therapist	057	
Psychologist	058	
Clinical Social Worker	059	
Public Health or Welfare Agency	060	Federal, state, and local government
Voluntary Health Agency	061	Planned Parenthood
Other Specialty Not Listed Above	062	Hypnosis
Respiratory Therapist	063	

Dental: (This list is <u>not</u> all inclusive.)

COMAR Practitioner Specialty	Value	Other Services Included
General Dentist	070	
Endodontist	071	
Orthodontist	072	
Oral Surgeon	073	
Pedodontist	074	
Periodontist	075	
Prosthodontist	076	

Office Facilities: (This list is <u>not</u> all inclusive.)

COMAR Practitioner Specialty	Value	Other Services Included
Freestanding Pharmacy	080	Includes grocery stores
Mail Order Pharmacy	081	
Independent Laboratory	082	
Independent Medical Supply Company	083	Durable Medical Equipment Prosthetic Devices Vision Products Blood
Optician/Optometrist	084	For lenses & eye glasses
All Other Supplies	085	
Freestanding Medical Facility	090	
Freestanding Surgical Facility	091	
Freestanding Imaging Center	092	
Other Facility	093	Dialysis Center Birthing Center

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Appendix E

Explanation of

COVERAGE TYPE

Formatted for 2008 MCDB data due June 30, 2009

Coverage Type

Coverage Type: The data field that indicates type of insurance coverage (i.e., individual market, Medigap, employer sponsored, etc.).

The following table lists COMAR Coverage Types and provides a column of mapping examples.

COMAR Coverage Type	Value	Examples of Coverage Type
Medicare Supplemental (i.e. Individual, Group, WRAP)	1	If your company provides Medicare Supplemental Insurance (Medigap)
Medicare Advantage Plan	2	• Medicare Health Maintenance Organization (HMOs) • Preferred Provider Organization (PPO) • Private Fee-for-Service Plans • Medicare Special Needs Plans • Medicare Medical Savings Account Plans (MSA)
Individual Market (not MHIP)	3	Most plans offer: • Conversion High • Conversion Standard • Direct Pay High • Direct Pay Standard • Student Health
Maryland Health Insurance Plan (MHIP)	4	• CareFirst of Maryland, Inc. • CareFirst BlueChoice, Inc.
Private Employer Sponsored or Other Group (i.e., union or association plans)	5	If your company is providing either administrative services only or standard insurance to an employer or other group in the private sector: • Commercial Basic • Commercial High • Commercial Standard • Preferred Provider Option • Triple Option • HMO • Point of Service • Triple Option HMO • Indemnity • Triple Option POS • Triple Option PPO
Public Employee - Federal	6	If your company participates in the Federal Employees Health Benefits Program
Public Employee - Other	7	If your company is providing either administrative services only or standard insurance to an employer or other group in the public sector including state, county, local/municipal government, or public school systems
Comprehensive Standard Health Benefit Plan (except HIP)	8	Participating carriers: • Aetna Life & Health Ins. Co. • Aetna US Healthcare Inc. • CareFirst BlueChoice, Inc. • CareFirst of MD, Inc. • Coventry Health & Life, Inc. • Coventry Health Care DE, Inc. • Graphic Arts Benefit Corp. • Group Hospitalization & Medical Services • Guardian Life Insurance Co. of America • Kaiser Permanente Mid-Atlantic States • MAMSI Life and Health Insurance Company • MEGA Life & Health Insurance Company • Optimum Choice, Inc. • United Healthcare Insurance Company
Health Insurance Partnership (HIP)	9	Participating carriers: • Aetna Life & Health Ins. Co. • Coventry Health & Life, Inc. • CareFirst of MD, Inc. • United Healthcare Ins. Co.

MARYLAND HEALTH CARE COMMISSION

Appendix F

2008 MCDB Payers & Payer ID Numbers

Data Due June 30, 2009

ORGANIZATION	Payer ID #	ORGANIZATION	Payer ID #
Aetna U.S. Healthcare	P030	Great-West Life & Annuity Ins. Co.	P330
Aetna Life & Health Insurance Co.	P020	Guardian Life Insurance Company of America	P350
American Republic Insurance Co.	P070	Kaiser Permanente Mid-Atlantic States	P480
CareFirst BlueChoice, Inc.	P130	MAMSI Life and Health Ins. Co.	P500
CareFirst of Maryland, Inc.	P131	MD-Individual Practice Association, Inc.	P520
CIGNA Healthcare Mid-Atlantic, Inc.	P160	MEGA Life & Health Insurance Co.	P530
Connecticut General Life Ins. Co.	P180	Optimum Choice, Inc.	P620
Corporate Health Insurance Co.	P220	State Farm Mutual Automobile Ins. Co.	P760
Coventry Healthcare of Delaware, Inc.	P680	Trustmark Insurance Co.	P830
Assurant Health/Time Insurance Co.	P280	UniCare Life & Health Insurance Co.	P471
Golden Rule Insurance Co.	P320	United Healthcare Insurance Co.	P820
Graphic Arts Benefit Corporation	P325	United Healthcare of the Mid-Atlantic, Inc.	P870

MARYLAND HEALTH CARE COMMISSION

Appendix G

MHCC INTERNAL DATA EDIT THRESHOLDS

PROFESSIONAL SERVICES DATA REPORT

100% COMPLETE –

PRACTITIONER FEDERAL TAX ID
SERVICING PRACTITIONER ID

5% THRESHOLD –

DATE OF BIRTH – Month of birth
CONSUMER DIRECTED HEALTH PLAN
PATIENT COVERED BY OTHER INSURANCE
PARTICIPATING PROVIDER FLAG
SERVICE LOCATION ZIP CODE
SERVICE UNIT INDICATOR
(Anesthesia time units/time minutes)
UNITS OF SERVICE
PROCEDURE CODE (Missing + Invalid + Homegrown)
NATIONAL PROVIDER IDENTIFIER # (NPI)

1% THRESHOLD –

DATE OF BIRTH – Year of birth
SEX
ZIP CODE
COVERAGE TYPE
DELIVERY SYSTEM
DIAGNOSIS CODE 1
PLACE OF SERVICE
DATE OF ENROLLMENT
DATE OF DISENROLLMENT

PHARMACY DATA REPORT

100% COMPLETE –

NCPDP Number
NDC CODE
DATE FILLED – Year filled

5% THRESHOLD –

PHARMACY ZIP CODE
NATIONAL PROVIDER IDENTIFIER # (NPI)

1% THRESHOLD –

PATIENT ZIP CODE
PRACTITIONER DEA #
DRUG QUANTITY
DRUG SUPPLY

PROVIDER DATA REPORT

100 % COMPLETE –

SERVICING PRACTITIONER ID
PRACTITIONER FEDERAL TAX ID
PRACTITIONER SPECIALTY 1

5% THRESHOLD –

NATIONAL PROVIDER IDENTIFIER # (NPI)
MARYLAND HEALTH PROFESSIONAL LICENSE #

1% THRESHOLD –

PRACTITIONER NAME (LN, FN, MI, Suffix, Cred)
INDICATOR FOR MULTI-PRACTICE FACILITY

MARYLAND HEALTH CARE COMMISSION

Appendix H

Timeline for the MCDB Data Expansion

2008 MCDB Data Submission (*due June 30, 2009*):

- **Voluntary Submission:** Institutional Claims File

2009 MCDB Data Submission (*due June 30, 2010*):

- **Mandatory Submission**: Institutional Claims File
  - 1st year of a 3-year transition to mandatory submission of most required data elements
  - Payers may request a waiver for a particular data element that they do not collect, but can demonstrate intention to collect in the future
- **Voluntary Submission:** Medical Eligibility File & Pharmacy Eligibility File

2010 MCDB Data Submission (*due June 30, 2011*):

- **Mandatory Submission**: Institutional Claims File
  - 2nd year of the 3-year transition to mandatory submission of most required data elements
  - Payers may request a waiver for a particular data element that they do not collect, but can demonstrate intention to collect in the future
- **Mandatory Submission**: Medical Eligibility File & Pharmacy Eligibility File
  - 1st year of a 3-year transition to mandatory submission of most required data elements
  - Race & Ethnicity are data elements in these files. The requirement to populate the race/ethnicity variables with responses other than "unknown" may be phased in over a longer time period by MHCC to address several issues:
    - Most payers do not now collect this data
    - Developing a data collection process for race/ethnicity is complex, time-consuming, and may be phased in with new enrollees
  - Payers may request a waiver for a particular data element that they do not collect, but can demonstrate intention to collect in the future

2011 MCDB Data Submission (*due June 30, 2012*):

 Mandatory Submission: Institutional Claims File

- Last year of the 3-year transition to mandatory submission of most required data elements
- Payers may request a waiver for a particular data element that they do not collect, but can demonstrate intention to collect in the future

 Mandatory Submission: Medical Eligibility File & Pharmacy Eligibility File

- 2nd year of a 3-year transition to mandatory submission of most required data elements
- The requirement to populate the race/ethnicity variables with responses other than "unknown" may be phased in over a longer time period
- Payers may request a waiver for a particular data element that they do not collect, but can demonstrate intention to collect in the future

2012 MCDB Data Submission (*due June 30, 2013*):

 Mandatory Submission – Full Compliance Required: Institutional Claims File

 Mandatory Submission: Medical Eligibility File & Pharmacy Eligibility File

- Last year of the 3-year transition to mandatory submission of most required data elements
- The requirement to populate the race/ethnicity variables with responses other than "unknown" may be phased in over a longer time period
- Payers may request a waiver for a particular data element that they do not collect, but can demonstrate intention to collect in the future

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